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Limited mouth opening and the intubating laryngeal mask

To the Editor:

Asai and colleagues report awake use of the size #4 intubating laryngeal mask (ILM) in a patient with a predicted difficult airway due to mouth opening limited to 20 mm at the incisors and <10 mm between the gums on the right.¹ Although the ILM has a good track record in the awake difficult airway,²⁻⁴ we consider that its use was unwise in this instance. Although the mean external diameter of the adult ILM tube (sizes #3, #4 and #5) is 17.6 mm, the maximum external diameter is 20 mm. This occurs in the plane of the tube's curvature at the point where it is overlapped by the proximal part of the cuff.⁵ Thus, placement of the ILM should be extremely difficult when mouth opening is limited to 20 mm and would put dentition at risk. We therefore consider that the adult sizes of ILM (pediatric sizes are currently planned) are relatively contraindicated if mouth opening is < 25 mm and absolutely contraindicated if ≤ 20 mm. Perhaps, in this instance, the authors would have been wiser to use the standard laryngeal mask airway which has a softer, narrower tube and has been placed in patients with mouth opening of 12-18 mm.⁶

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REPLY:

Although the conventional laryngeal mask could have been used, this does not necessarily mean that the laryngeal mask would have been a better choice than the intubating laryngeal mask. The latter has several advantages over the laryngeal mask. First, whereas it is necessary to insert the index finger into the oropharynx to drive the conventional laryngeal mask reliably into the correct position,^{1,2} it is not necessary for the intubating mask.³ Therefore, when mouth opening is restricted, correct positioning of the intubating laryngeal mask may be easier. Second, after insertion, adjustment of the mask position is easier for the intubating mask than the laryngeal mask.³ Third, the intubating laryngeal mask allows for passage of a larger-bore tracheal tube.³ These advantages should be balanced against the possible disadvantage of the intubating laryngeal mask-damage to the teeth. We thought it justifiable first to attempt to insert the intubating laryngeal mask without undue force, and if there was difficulty, alternative methods, such as fibroscope-aided intubation with/without LMA, would be tried. In fact, there was little difficulty in insertion by rotating the device to the side when the curved part of the metal tube was passing behind the upper teeth.

We believe that all intubation techniques have disadvantages and contraindications and that indication of each technique should be considered in each patient.

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Lower extremity temperature disparity after retroperitoneal dissection

To the Editor:

Combined chemotherapy and radical surgery are employed to treat patients with testicular carcinoma. Scardino and Skinner have demonstrated bleomycin and cisplatin therapy followed by thoracoabdominal dissection to be curative.¹ Surgery involves resection of retroperitoneal tissue and lymphatics from the pelvis to the diaphragm.^{2,3} Postoperatively, 30 - 40 % of these patients present with temperature disparity between the lower extremities.

A temperature difference of this type raises concern about a cold extremity and possible vascular insufficiency or embolic complication - and can result in extensive additional workup. Furthermore, heparinization may be considered and increase the risk of postoperative bleeding. On examining these patients, we have found that the warmer leg is on the same side as the surgery, and Doppler studies consistently fail to demonstrate vascular abnormalities. Surgical dissection involves removal of retroperitoneal tissue which may include sympathetic ganglia and nerve fibres. This results in vasodilatation and production of warmth in the ipsilateral lower extremity. The temperature difference is typically 2 to 3°C and partially resolves over several weeks.

Lower extremity temperature disparity can result from (i) less warmth in one extremity secondary to decreased blood supply or from (ii) relatively more warmth in one extremity secondary to comparatively increased blood flow (as discussed here). Clinically, discriminating between these two etiologies is difficult because expected postoperative temperature variability makes it impossible to label one limb's temperature as *normal*.

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Interscalene brachial plexus block and pulmonary function

To the Editor:

We compared the effects of posterior and lateral approaches to Interscalene Brachial Plexus Block (IBPB) on respiratory function. Fifty consecutive ASA I-II patients, scheduled for elective upper extremity surgery were studied. Arterial blood pressure, ECG and peripheral oxygen saturation were monitored during the surgical procedure. The subjects were randomly allocated in two groups of 25. Interscalene brachial plexus block was performed by the lateral approach of Winnie¹ in group I and by the posterior approach of Pippa *et al.*² in group 2. In both groups 40 ml of anesthetic solution (20 ml prilocaine 1% and 20 ml bupivacaine 0.5% were administered. Respiratory function measurements were performed in the operation room using Autospiro AS 500 apparatus (Minato, Japan). Forced vital capacity (FVC), Forced Expiratory Volume at first second (FEV₁), and

TABLE Decrease (%) in respiratory function after IBPB.

	2 min		5 min		10 min		15 min		30 min	
Group	I	II	I	II	I	II	I	II	I	II
FVC	13.4*	15.5*	17.0*	21.0*	20.3*	22.2*	25.3*	30.1*	25.6*	32.2*
FEV ₁	11.8*	11.1*	15.0*	19.1*	19.6*	24.4*	24.1*	29.1*	25.2*	31.1*
VC	18.7*	18.8*	24.0*	31.0*	27.1*	33.8*	28.2*	38.2*	29.5*	37.3*

* $P < 0.05$ compared with baseline measurements.